Commonwealth of Virginia
Department of Human Resource Management
Administrative Services and Fully Insured Health Benefits Plans
RFP # OHB19-01

Addendum # 1
August 28, 2018

This addendum is issued to respond to questions received at the mandatory pre-proposal meeting held on August 20, 2018. The submission date remains unchanged.

Please sign this form and include as a part of your submission.

X_____

1. Is there interest in receiving a standalone Vision and Hearing Aid proposal?

   Stand-alone vision and hearing submissions will not be accepted. As explained in Section 1.1, any submission must address all elements of a given component. For components one and two, it is explained that the medical/surgical offeror may choose to subcontract other vendors to propose the required single offering for this component. For component five, the fully-insured offering must contain all major elements of the other components and may include additional elements such as vision and hearing.

2. The link is not working in section 2.9.6.26 Regarding the Escheatment process.

   The correct link is: https://www.vamoneysearch.org/Report

3. The link in Appendix 5 for the Transaction file format is not working.

   Updated links are: http://web1.dhrm.virginia.gov/itech/files/AuditFileLayout.pdf

   And http://web1.dhrm.virginia.gov/itech/files/ChangeFileLayout.pdf

4. (8/8/18) Cover Sheet of the RFP states that the period of contract is "from July 1, 2019 to June 30, 2024, with five one-year renewal options," but the General Terms and Conditions state that, "the term of this contract is three years with four one-year renewal options." Please confirm which is correct.

   The term of the contract will be 5 years (July 1, 2019 through June 30, 2024) with five, one (1) year renewal options.

5. (8/8/18) Appendix 9- Will you please send a new version – The check box and signature line appears to have been cut off.

   SEE ATTACHMENT (APPENDIX 9)

6. On pg. 41 & 42, section 6.6.1, 6.6.2, and 6.6.3 reference a fixed price for years 1, 2 and 3 respectively. If a three year contract with four one-year renewals, would indexing from year 3 be appropriate? Or, if each year is a one year contract, is the intention to have a fixed fee for years 4 and 5?

   There should be a proposed fixed fee for years 4 and 5.

7. For bid submissions, is a USB drive an acceptable substitution for a CD? Or is a CD preferable?

   The CD is preferable

8. In section 6.8, scoring is illustrated/explained by component. Within component 1 and 2, behavioral health and vision/hearing are broken out. However, the cost exhibit does not break these out. Does the cost exhibit need to be amended to reflect this level of breakout? If not, could you explain how will behavioral health & vision/hearing be scored as illustrated in section 6.8?

   (WAITING ON ANSWER FROM AON)

9. Can larger documents be placed on CD (or possibly USB) rather than printed (e.g. GeoAccess reports, Sample Reporting, Sample Communication Materials, etc.)?

   These reports should be printed out and submitted pursuant to the number of copies specified.

10. **RFP Section Component 6:** Please confirm a fully insured health benefit plan does not need to respond to the FSA portion, Component 6.

    Confirmed

11. **RFP Section Medical Questionnaire**: As we complete the RFP Questionnaire, would you like us to expand on "yes" drop down answers or do you prefer explanations on "no" answers only?

    Providing additional clarification on any "yes" response is acceptable. Per the instructions a detailed explanation is required for any "no" response.

12. **RFP Section Medical Questionnaire**: How would you like us to respond to the Questionnaire tab lines 274-276, 435-437? There appear to be AON internal notes in the response cells.

    Whatever appeared to have occupied that space has been removed. Consequently, you should be able to provide a response.

13. **RFP Section Medical Questionnaire**: Are the two requests on the Questionnaire tab: Exhibit 4 (line 276) and C-4 Standard Report (line 467) for the same attachment?

Yes the questions are redundant. Therefore answer Exhibit 4 (line 276) only.

14. **RFP Section Medical Questionnaire**: For the EAP tab, lines 10-50, please indicate your preferred method of response. Would an indication of included/not included be considered responsive or would the group prefer more detail?

A response of included/not included will suffice but succinct responses that provide clarification/detail are acceptable.

15. **RFP Section Medical Questionnaire**: Please confirm a fully insured health benefit plan does not need to respond to the Cost Containment Tab.

Confirmed

16. **RFP Section Medical Questionnaire**: Please confirm there is no "Provcnt" tab to be completed according to MISA Questionnaire tab, line 166.

Please disregard as this information will be captured in the Geo-Access reports.

17. **RFP Section Medical Questionnaire**: Please share the diagram and form referenced in the MISA Questionnaire tab, line 432 for completion.

There is no diagram to complete. What is being requested is for the offeror to provide information on the systems and interfaces used for the noted functions in Section IV.

18. **RFP Section attachment 2**: Please provide a breakout of the medical claims data by county.

Monthly claims and enrollment data by County for the COVACare, LODA, and TLC plans for medical and RX is available and will be provided upon request.

19. **RFP Section Attachment 2**: Please provide the schedule/instructions for completion of the proposal referenced in this section.

No instructions or schedule needed. The text is indicating claim and enrollment information are available that will help bidders provide a complete response.

20. **RFP Section Pharmacy**: Is the current RX rebate passed back to the Commonwealth or is it provided in the form of a credit in the administrative Fee? If in the form of a credit, what is the current PEPM Rx rebate credit?

The RX rebate is passed back to the Commonwealth.

21. **RFP Section Component 5**: Please confirm if there are any sections from the RFP or from the Technical Questionnaire that should be responded to differently based on Component Number 5, a fully insured proposal. Component Number 5. For example, Component Number 5, states a fully insured offering must contain all major components of the major components. Please clarify the applicable major components.

Please note a fully insured offer is to be self-contained which infer the inclusion of medical/surgical, behavioral health, pharmacy, vision, hearing and dental. The only exceptions for fully insured respondents will be the cost containment and self-insured fee tabs. Everything else is deemed pertinent to your response.

22. **RFP Section Medical Questionnaire:** Our company is interested in offering vision and hearing benefits to the Commonwealth of Virginia. Can you please release credentials to obtain the electronic files via a secure method?

The Commonwealth is not accepting offers for standalone Vision and Hearing benefits. As per the instructions, these benefits will be bundled with medical plans.

23. **RFP Section Dental Component 4:** Are you requesting a fully insured dental plan (in addition to the self-insured request) for the entire group or just a subset of the entire population.

Component 4 is soliciting only a statewide administrative services offer for the state employee, TLC and LODA plans. The Commonwealth of Virginia will not accept quotes for less than statewide or subset populations for Component 4.

24. **RFP Section Dental Questionnaire**: What is an Employer Group Waiver Plan?"

Please disregard and select "Not Applicable" from the options listed in response to question 3 on the Minimum Qualifications tab of the Dental Questionnaire

25. **RFP Section Medical Questionnaire**: Question 4: In section 6.8, scoring is illustrated/explained by component. Within component 1 and 2, behavioral health and vision/hearing are broken out. However, the cost exhibit does not break these out. Does the cost exhibit need to be amended to reflect this level of breakout? If not, could you explain how will behavioral health & vision/hearing be scored as illustrated in section 6.8?

Use Row 32 in the medical cost exhibit to provide your fees/cost for behavioral health. Separate rows have been created to capture fees/cost for vision and hearing services.

26. Medical Technical Questionnaire (same questionnaire for component 1 and 2) – Cost Containment tab – cells do not wrap text thus answers are cut off

Dental questionnaire - Some cells cut off the full question and in some instances the drop downs are not working. Examples are lines 55, 59, 63 and 67

FSA questionnaire – We are unable to extend the cells in the explanation tab

Rx questionnaire - Explanation column…we are having issues entering information into the tab. When we try to enter it we get the following message, even though we are not entering that many characters.

Each of the issues identified in the respective questionnaires have been addressed/remedied and revised questionnaires will be sent to all affected offerors. With respect to the Rx questionnaire use the explanation tab provided in the questionnaire which has no character limits, for longer explanations.

27. There are several references in the Component 3 (Prescription Drug) questionnaire that reference a service warranty. Could you advise of any details that may be of use to a bidder that describes a service warranty?

Service warranties are reports which are produced after becoming aware of client service issues. For example, if an audit found that a PBM/insurance carrier was adjudicating a drug at the wrong copay, the service warranty report would outline the miss and how the PBM/insurance carrier plans to remunerate the plan and/or members.

28. Do the subcontractors have to be DSDC certified? Can some have this certifications and others not? Also, is the 42% of the annual fee Kaiser pays?

Both questions will need further clarification to facilitate a response.

29. Would COVA consider an alternate Deductible HMO plan or an HSA plan to be offered statewide and for The Local Choice alongside the existing HMO plan?

Offeror(s) should submit proposals that are consistent with the RFP, and specifically with the Component(s) for which the Offeror is proposing. However, there is an innovation section in the questionnaire which will allow offerors an opportunity to provide options.

30. Does the criteria in 2.3.2.1 through 2.3.2.8 apply to our less than statewide plan?

Yes.

31. COMPONENT NUMBER FIVE (Fully-insured regional offerings for state employee and TLC plans) A fully-insured regional offering must contain all major elements of the other components (Medical/Surgical, Behavioral Health/EAP, Prescription Drugs, and Dental). It may also offer additional elements, such as Vision and Hearing for the fully-insured regional offering, will our Medical/Surgical questionnaire response meet the requirement, because our integrated delivery system includes behavioral health, pharmacy, vision etc.? Or is it COVA's intent to have each questionnaire completed?

Yes.

32. SUBMISSION OF WRITTEN PROPOSALS 5.2.1…An Original, a Redacted Electronic Copy and twelve (12) hard/paper and twenty-five (25) electronic copies of the original, on separate CDs, shall be delivered in a sealed container, and labeled as a proposal, with

the words "Do Not Open" and the type of benefit plan enclosed prominently displayed on the outside… Will COVA accept flash drives (removable storage) in lieu of CDs?

We will only accept CD's

33. 6.3.1 For all plans within all components except Number Five, itemize any benefit changes to current plans. Please confirm that plan Number Five will not need to itemize benefit changes to current plans?

Confirm; however, Offerors for Component Five should provide the total plan design for their fully-insured option.

34. What type of ancillary information (i.e.should be displayed on the ID card: name/phone number or benefit information? If benefit information, how will the Commonwealth be sharing that data with the medical carrier?

It is expected that the ID card includes name, member ID, group number, Rx Bin, PCN, Rx Group, PCP and specialist copay or coinsurance, other identifier for claims administrator, claims administrator logo, plan logo, ancillary benefit logo(s) or other identifier(s), applicable customer and provider services numbers. The Commonwealth expects that the medical carrier will work with other vendors and the Commonwealth's systems team to develop the card, as approved by the Commonwealth.

35. For the annual member satisfaction survey referenced in RFP sections 3.8, 4.1.8, and in the *Questionnaire* tab (line 510), would the Commonwealth like to use our CAHPS survey for commercial business or is the Commonwealth requesting a satisfaction survey specific to COVA members?

The Commonwealth requires a satisfaction survey specific to COVA members.

36. It does not appear the Anthem COVA information includes Rx, can you please confirm? If it does not, can the Commonwealth provide the RX paid claims for the period 5/2016 – 4/2018 be shared for the state and TLC plans?

The Rx data was provided for all plans for the 5/1/2017-4/30/2018 period

37. Please share high claimant information for both COVA and TLC for the following paid periods:
- Paid 5/2016 – 4/2017
- Paid 5/2017 – 4/2018

High cost claimant information for the most recent period noted above was provided.

38. Please confirm which sections of the Pharmacy questionnaire should be completed as a part of a regional, fully-insured proposal. For instance, would the Commonwealth like

responses to the Pricing Guarantees section and the Medicare Part D: RDS section in the Questionnaire tab and the RX-Pricing, MFP tab?

Please respond to all pharmacy RFP tabs except the *RX-Pricing, MFP* and *RX-Pricing, Transparent-Broad*. Please disregard the Medicare Part D: RDS section of the *Questionnaire*.

On the Questionnaire tab, please confirm if the question on pre-determination of benefit threshold amount (line 344) is related to pre-service thresholds, claims thresholds, or benefit limits.

Claims Threshold

39. On the Questionnaire tab, please confirm how eligibility data is being used online and in what online system it should be made available for use (line 495).

The intent of the question is to confirm you will load, test and verify eligibility data according to a mutually agreeable implementation timeline.

40. In prior RFPs, we met the requirements of Section 6.2 (Redline RFP noting demurrals) by providing a response to each section directly after each requirement. Is this still acceptable, or do you require us to use the actual "track changes function" in Word? We have attached an example of each (Redline Example 1, Redline Example 2).

Follow the instructions in 6.2.

41. If we are required to use the Track Changes function (in Redline Example 2), can you please provide a copy of the RFP document in Word format, as only a PDF version was posted to the Website?

The RFP is available in Word format on the DHRM web site.

42. Section 5.2.1- Can you confirm if you require 25 electronic (CD-ROM) copies in total, or if in addition to the 25 copies, you also require an electronic copy (CD-ROM) in each hard copy binder?

There should be 25 CDs 12 of which can be included in the Binders.

43. Can bidders provide large files (such as disruption details, annual reports) only in electronic format?

Files must be printed out as well

44. Can you confirm if Small Business Participation, referred to in several sections (6.7; 7.0 8.27, Exhibit 2) is a goal of the RFP, or if there is an actual spend percentage bidders need to make?

It is a goal and a preference of the RFP. There is no spend percentage associated with it.

45. Can you confirm we do not need to provide any additional items aside from the requested pricing sheets asked for in Item 6.6 in order to meet the requirements of Section 8.26 (electronic catalog)

The Electronic Catalog is the requirement after the contract is signed and orders may need to be submitted through EVA.

46. In the "Directions to Complete Workbook Tab" of the COVA Dental RFP 2019 Workbook, you ask that we include and original hard copy and six electronic USB drives. Could you confirm that this in superseded by and inclusive in, the requirement in 5.2.1 (1 Original, 12 Hard copies, 25 electronic copies)?

The instructions in Section 5.2.1 supersede all other requirements pertinent to number and types of copies.

47. The "NAPD" Tab of the Dental Workbook and "GeoAccess" Tab of the medical workbook instruct us to send the Geos Access and Disruption files back to hnadpmbx@aon.com. Can you confirm if we only need to send them back to this address, and not include them in the response back to the State?

Confirmed

48. On the RFP cover page, you state that the Period of Contract is "From July 1, 2019 through June 30, 2024, with five one-year renewal options as described within", and in Section 8.2 (Renewal of Contract) you state that "the term of this contract is three years with four one-year renewal options. Can you please clarify the contract period for each of the components?

The term of the Contract is 5 years with 5 one year renewals.

49. Can you provide clarity around your existing Total Population Health program and vision for the future? If the TPH functionality will be fully managed by the health carrier, is the intent to replicate the current program platform and design (including customizations such as VBID, Premium Rewards, Bariatric Pre-Education program) or for the respective carrier(s) to perform their core capabilities?

TPH functionality is to be managed by the medical/surgical administrator, which will be expected to be able to replicate the current program design, including customizations.

50. Can you provide clarity on the data aggregation and analytics functionality? Will that be retained through the current vendor?

Data aggregation and analytics functionality is not addressed by this RFP except that contractors will be required to provide information to a dedicated data warehouse.

51. What is the vision for the on-site lifestyle coach? Will there be one location at the existing Capitol Square HealthCare, coach for only the PPO and HDHP health plan, services they will provide?

Work with the information in the RFP.

52. For the COVA Health Aware and COVA HDHP products, what is the intent for Rx integration if administered by a separate vendor?

Work with the information in the RFP.

53. In reference to Pg. 24 Section 2.9.3.1, subsection Z.dd, can you elaborate on the Commonwealth's expectations for each component related to pharmacy transparency? What are the specific policies and procedures?

Policies and procedures should ensure compliance with the requirements as outlined.

54. Can you provide details on the format, frequency, method and other technical elements of the EOB process?
Is there a reporting format that outlines required fields and methodology?

Provide, at a minimum, the information listed in the RFP.

55. Can you provide the additional pharmacy data listed below, if so, what is the projected distribution date?

1) Preferred = Full claim file, including:
   a. Claim Information by Drug dispensed for a 12 month period (note period)
   b. Average employee counts and members for claim information provided
   c. Date of Service
   d. National Drug Code (NDC) = 11 digit number
   e. NABP (Pharmacy) Number
   f. Quantity Dispensed
   g. Days Supply
   h. Retail/Mail Indicator
   i. Brand/Generic Indicator

(2) Acceptable = Summary of claim information, including all or some of the following:
   j. Average days supply (Retail and Mail)
   k. Scripts/ee/year
   l. latest 12 months of scripts
   m. split between retail and mail
   n. retail split between brand and generic
   o. mail split between brand and generic

This information has been provided.

56. Please provide a description of any current / projected pharmacy clinical and or utilization management programs. (clinical / financial).

Use resources to which the RFP has referred has referred and the attached high level

PlanDesigns_COVA.xlsx

summary of current programs (also see attachment).

57. Will The Commonwealth accept a traditional pharmacy financial arrangement? If not, at minimum would you accept a traditional arrangement for mail service and specialty pharmacy claims?

No

58. Does the Commonwealth administer any kind of "narrow pharmacy network" today? If not, would the Commonwealth consider a more narrow pharmacy network?

The Commonwealth does not currently require use of a narrow pharmacy network. The Commonwealth will consider other options; however, it may not implement them.

59. Can you provide more detail around the dental offering? Will the medical product still provide routine coverage and the dental buy-up product provide other coverage? Or will the dental vendor provide all dental services?

Offerors will be required to, at a minimum, replicate the current benefits structure.

60. Can we get a Dental PPO in network utilization and discount report for the most recent 12 months?

Discount levels will not be provided as it is deemed proprietary information. A summary utilization report has been provided. OON utilization for the Delta Dental plans covering the 7/1/17-6/30/18 period are as follows:

State- 9.6%
TLC-9.9%
LODA-4.6%

61. Can we get a census with an additional column with a clear indication of the current dental carrier?

The census file previously shared contains this information. Members in the Health Aware plan are tied to the Aetna dental plan and those in the COVA Care plans are affiliated with Delta Dental. If additional clarification is required please let us know.

62. What is driving the Commonwealth's evaluation of FSA services?

Use the information in the RFP.

63. Who is the current FSA vendor?

Anthem/WageWorks, Inc.

64. Is the Commonwealth satisfied with the service level of current vendor? If yes, why are they evaluating? If no, please explain the cause of their dissatisfaction.

The existing contract will expire on June 30, 2019.

65. How many participants are currently enrolled in FSA?

Work with the information in the RFP.

66. What are the current vendor fees for FSA services?

Prefer not to disclose

67. What are the next steps after completing an evaluation of the completed RFP?

Refer to the RFP.

68. It is noted that the Commonwealth offers an HDHP, will they also entertain quotes on HSA administration?

Refer to the RFP.

69. We have not received the GeoAccess and Disruption documents as of yet. When can we expect them to be distributed?

All geo-access and disruption documents have been released. If you have not received them please contact Brian Dwyer at brian.dwyer@aon.com.

70. On the Census, there is a LODA plan 3 but there are only LODA 1 and LODA 2 plan designs on the website. Could you please send the plan for LODA 3?

Please disregard LODA Plan 3. It is not currently being procured.

71. Question 2.4.4 - To be awarded a contract, all plans must demonstrate the capability to provide the claims and eligibility files in a format required by the Department. Such demonstration will consist of submission and approval of a test file in the format provided to finalists. The timing and other logistics involved with this process will be determined during the proposal evaluation and negotiations. Could we get a sample of the format required?

This information will be shared with the finalist(s).

72. Question 2.5.14 - Provide, on a schedule to be determined, an electronic claim file to a designated data warehouse. Could we get a sample of this file and who the data warehouse is?

This information will be shared with the finalist(s).

73. Question 2.8.8 - The Contractor(s) shall work with the Department and other vendors in the creation and distribution of single, plan-specific ID cards. This means that, at a minimum, the single ID card must include all necessary information related to the Medical/Surgical, Prescription Drug, Behavioral Health, Dental, Vision and Hearing benefits. The common ID card should not include a Social Security number; it should provide the unique, personal ID number generated by the Department. The selected Offeror for the Medical/Surgical product will be responsible for providing this single ID card. Could we get a copy of the current ID card that reflects this for review?

Work with the information you have.

74. Are there any dedicated services required – onsite FTE, claim office, call center, etc?

Use the information you have.

75. What are onshore requirements?

Use the information you have.

76. Regarding TLC:
How many localities currently participate?

Our most recent information indicates 350 entities.

Is structure expected to be separate for each locality (i.e. will they require separate policy numbers)?

Yes

Will bank accounts have to be set-up individually, so that each locality is not able to view the information of another?

No. There is a health insurance fund for the TLC program to which the premiums for the entities are deposited and from which claims are paid.

Use the demographic information you have. Structure must be organized to identify separate groups.

79. Regarding LODA – are separate policies and/or bank accounts required?

All information regarding LODA must be identified separately. Anthem direct bills participating groups. No bank accounts are necessary.

80. With respect to references in the RFP to multiple vendors, is there an opportunity for us to offer admin fees on a tiered enrollment basis? If so, in what format should we respond given the Self Insured Financial Exhibit is based on a full replacement quote only.

Yes. Please provide as an addendum your enrollment based fee offer.

81. Confirm that if we offer a proposal for Component Two only, that the only portion of the Self Insured Financial Exhibit that we would need to complete is the COVA HealthAware column.

Confirmed

82. The Self Insured Financial Exhibit indicates that admin fees should assume Rx is carved out. Does this mean that COVA is not considering an integrated Med/Rx approach?

COVA will consider an integrated Med/Rx approach. The intent was to review each component separately. If you propose, as an option, a consolidated offer please reflect the impact in the medical financial fee exhibit.

83. Section 2.9.1.1 – re: Capital Square Healthcare Clinic – please provide additional details around the expectation of integration. Will we be expected to include in our network? What services are offered here? Is there an onsite pharmacy? How are claims currently handled – submitted or suppressed?

Capitol Square Healthcare does not participate in any network at this time.
Information is available at the following link:
http://myquadmedical.com/wp-content/uploads/2017/11/cova_handout_faq_final.pdf

84. Are the Performance Standards and associated Liquidated Damages requirements of the RFP or will alternate solutions be acceptable?

Work with the information you have.

85. Will our bid be disqualified if we are unable to breakdown our admin cost to the full itemized detail requested in the Self Insured Financial Exhibit?

Offerors must provide as much detail as possible with respect to administrative fee cost components. In addition, they must provide an explanation why compliance is not possible for specific fee components. Shared savings fees must be reported (applies to self-insured plans only).

86. Regarding the allowances/credits listed in the Self Insured Financial Exhibit, are there any specific amounts by category that COVA desired or is this being left to the sole discretion of the offeror?

There are no specific targets and any allowances/credits will be left to the discretion of the offeror.

87. Please provide the definition of Claim Fiduciary – Level 1.

Provides only advice on decisions

88. Regarding the experience data
Is there any stop loss in place currently? If so, at what ISL level?

Stop loss insurance is not purchased by any of the groups (State, TLC or LODA). However, a stop loss risk pool charge is built into the premiums for every entity. The amount will vary by entity based upon their size.

Is claim data net or gross?

Net

Why is LODA data only from 7/2017 thru 4/2018?

Current program inception on 7/1/17.

Is additional data available?

No

Are Hearing and Vision claims included in the COVA medical claims?

Included in the medical

What about COVA Rx data?

Previously provided.

Please provide enrollment data to correspond with the monthly claim data for the CDH.

Please refer to the enrollment report.

Only TLC has any stop loss protection. LODA was newly implemented effective July 1, 2017.

89. Per the Cost Containment tab of the Questionnaire, we are being asked to provide an estimate of cost for any programs charged on a contingency fee basis. What are the programs currently in place that are charged on this basis? Please provide current % of savings and utilization data for these programs. Additionally, please provide detailed claim data for current plans including out-of-network utilization/claims.

Currently, there are no programs with a contingency fee arrangement.

90. Provide clarification on section 2.9.1.1.d, Reference-based pricing. How does COVA define Reference-based pricing?

Work with the information you have. The traditional definition encompasses an amount specified for certain non-emergent medical procedures. What procedures that might be covered by RBP have not been identified and will be determined by COVA.

91. Is there interest in having an RBP solution available in year 1, or launched in subsequent years?

Offeror should be prepared to implement at any time on or after July 1, 2019.

92. What is the range of procedures/provider types that you are interested in having in scope for an RBP solution? Is it only for "shoppable services" (such as some radiology services or outpatient surgeries)? Or would it be for all types of care?

Please provide your ideas for RBP.

93. Is there interest in RBP for both Network and Out-of-Network providers? Or only Out-of-Network providers?

Please provide your ideas for RBP.

94. Is there interest in having consumer protection (such as bill mediation and consumer advocacy) available as part of an RBP solution? Is there interest in consumer-centric

alternatives to RBP, such as transparency tools for shoppable services and differentiated benefits for better value providers?

Please provide your ideas for RBP.

95. The RFP mentions that one or more vendors may be selected. Is that one or more vendor per component or per plan? For instance, Component 1 includes PPO and HDHP. Is it possible that the Commonwealth would award one contract on the PPO but two contracts on the HDHP?

The intention is to select only one contractor for all components except number five.

96. Regarding Appendix 5 - State Employee Eligibility, Enrollment and Administrative Billing. Would COVA consider alternatives to paying claims from your benefit bank account? In addition, would COVA consider an alternative to using a EDI file format for claims and administrative billing? Would COVA be willing to allow Contractor to pull funds or would State be willing to initiate funding.

COVA is willing to receive a weekly billing from the vendor for claims and a monthly administrative billing and pay that vendor based on the billing. Currently, we use EDI

97. Please confirm this RFP does not include post 65/Medicare eligible members? Line 121 of Rx questionnaire references Medicare/RDS support. Please advise.

Confirmed. Disregard the question.

98. 10,000 retirees are pre-65 and covered under the overall plan?

Pre-65 retirees are covered under the overall plan.

99. Please confirm the Rx benefits are carved-in today?

Confirmed

100. Please confirm if the plan is considering carve-out pharmacy options?

Use information that you have.

101. Is the plan to consolidate all members under one pharmacy vendor? Is their potential for Rx membership to be split across multiple vendors?

Use information that you have.

102. Please confirm the pharmacy vendors today currently providing PBM services?

Anthem/ESI and Aetna

103. Please provide employee count by pharmacy plan design/vendor?

This information is on the census file. Approximate number are: Aetna: 6,451 employees; 13,192 members. Anthem: 175,461 members.

104. Does the plan currently have an open or exclusion based PDLs across the various plans? If exclusion how many exclusions are implemented on the PDL?

Open PDL without exclusions across all plans.

105. Does the plan have any mandated mail incentive program? If so what are the details?

Mandatory mail has not been implemented.

106. Does the plan offer an open or exclusive specialty network?

Open specialty network

107. Does the plan have any incentivized retail 90 program like maintenance choice in place? Please provide details if so.

Neither plan has an incentivized retail 90 program

108. What is meant by mail-at-retail 90 day network in the RFP? Does the plan receive the same pricing at retail 90 as mail today?

We are asking for 2 sets of pricing and network disruption: one set for a broad 90DS network and one for a limited network in which 90DS scripts receive the same pricing as mail at select retail locations ("mail-at-retail"). No the plans do not receive the same pricing at retail 90 as mail today

109. Is the 90 day network broad or limited to certain pharmacies?

More clarification has been requested and will be shared when available.

110. Please provide details on who and how the final decision will be made?

Use the information you have.

111. Please confirm MAF is to be passed through on the rebates?

Confirmed

112. Per the RFP: 3. Statewide PPO, HDHP, and CDHP Prescription Drug administrative services for the state employee, TLC, and LODA plans. Is the intent for PBMs to provide a carve-out or carve-in solution?

Use the information you have.

113. Please confirm the intent is for PBMs to pass-through 100% of all rebate revenue, including manufacturer admin fees?

Confirmed

114. Will full line by line pharmacy claims data for the last 12 months be made available for each of the population groups?

Yes, this information has been provided.

115. Please clarify the intent of the transparent pricing requirement. Is the client billing required to match the pharmacy reimbursement at the claim level (i.e., true pass-through of retail pharmacy reimbursement rates), or is the vendor merely required to disclose all payment details (including retained spread, if any) for each claim?

Yes, the contractor is required to match the pharmacy reimbursement at the claim level.

116. Please clarify whether the "Brand Drug" definition in item #21 of the Rx RFP will apply to brand script counts used in Manufacturer Payment guarantee calculations (i.e., all brands as defined by a nationally recognized source must be included in the denominator of the per brand script guarantee calculation).

Confirmed

117. Does the plan currently use a standard vendor PDL, or a custom PDL? Is it expected that the plan will make custom changes to the vendor's proposed PDL?

Open PDL without exclusions. We have asked for pricing and disruption for a standard PDL with exclusions and a PDL without exclusions.

118. Is it required that the AWP discount in the adjudication cost formula requested in the Rx RFP be disclosed, guaranteed, and reconciled separately from the overall effective-rate discount guarantees?

Yes

119. What is the estimated cost of the RFP marketing noted in item 60.a. of the Rx RFP, and will the winning vendor be expect to reimburse COVA for that amount?

Please disregard

120. Is there a spending goal associated with obtaining the 20 points for SBE participation? If so, please provide details.

Other businesses that are not DSBSD-certified small businesses will receive credit based on their Small Business Subcontracting Plan not to exceed 75% of the points assigned to this evaluation criterion i.e. 20 points X 75%= 15 points. Points will be assigned based on each offeror's proposed subcontracting expenditures with DSBSD-certified small businesses for the initial contract period as indicated in the offeror's submitted subcontracting plan in relation to each offeror's total price. The Offeror's proposed subcontractor use of DSBSD-certified small businesses is divided by the Offeror's total proposed price. The quotient is then multiplied by the points assigned for the criteria to determine the evaluation points to be assigned.

Only DSBSD-Certified Small Businesses will receive the full 20 points.

121. Are the participation points available to all bidders or just the bidder with the highest level of participation for SBE?

Yes

122. For the SBE, are there points awarded for "Good Faith Efforts"?

No

123. Does Delta have separate SPDs specific to Dental or is the outline in the SPDs on site only details for LODA and COVACARE and COVA HDHP?

Use Member Handbooks/SPDs available online.

124. Appears some dental services like surgical removal of impacted teeth are covered under Medical (administered by Anthem Blue Cross and Blue Shield). Are they set up on Dental to be not covered or would the professional fee for oral surgeon be available for benefit under Dental?

Use information you have.

125. Can we confirm the COB Rule for Dental? Is it Come out Whole or COB to Allowable?

Refer to the COB explanation in the existing Member Handbooks.

126. LODA has two SPDs. Appears Dental benefits are identical. Just want to confirm?

Confirmed

127. Is there a separate dental plan through Anthem BCBS for Medicare Retirees that we should be quoting?

Refer to Section 1.3 of the RFP.

128. Under the COVA HDHP Member Handbook and Expanded Dental Benefits section - Under Primary Dental care, the last service listed is trips by the dentist to your home if you need any of the services you see listed here. What does this cover and what are the details? Is there CDT code used like D9410?

Use information you have.

129. Dental benefits appear to be very much the same across the groups for Delta Dental? Is this an accurate statement?

Use information you have.

130. Is COVA HealthAware include Dental benefits under Delta Dental? It reads like Aetna?

Refer to COVA HealthAware Member Handbook if you are seeking information regarding current benefits.

131. Can we confirm all of the Dental plan offerings and who administers?

These are available in the current Member Handbooks.

132. Does the vendor need to be SSAE 16 certified as part of the quote or can they have a comparable reporting capability and still be considered?

If SSAE 16 certification is not used please identify the substitute reporting capability

133. Only experience data for COVA Care, COVA HDHP, & TLC with Delta. Could we get the experience data that would include monthly claims & enrollment for the following:
    a. COVA Health Aware (Aetna)
    b. COVA Retirees (Anthem)
    c. LODA (Delta)

The Health Aware information was provided. Retiree claims are included in the Anthem total experience. LODA (Delta) has been requested.

134. Can you confirm current funding for the dental and vision?
    a. COVA Care, COVA HDHP, COVA Health Aware, Retirees – ASO or FI ?
    b. TLC – ASO or FI? Quoting ASO & FI?
    c. LODA – ASO ? Quoting ASO only?

Refer to the RFP.

135. What are the current ASO Fees/Fully Insured rates for the dental and vision?

This is not relevant to the current RFP. We are interested in your best pricing.

136. What is the current OON reimbursement – MAC or UCR?

Aetna- 80th percentile and Delta-MAC

137. Could we get the full dental and vision SPD's?

Use available SPDs.

138. Could we get a utilization report based on type of service (exam, frames, lenses)

The utilization report pertinent to State, LODA and TLC groups for the FY 18 have been provided.

139. Does the Commonwealth envision a separate, dedicated line for behavioral health crisis calls?

See Section 2.8 of the RFP.

140. How does the Commonwealth define a “crisis call” for this behavioral health line?

Any call to the crisis line should be handled in accordance with the requirements outlined in the RFP.

141. If our Behavioral Health calls are answered 24 hours a day, 365 days a year, and we include an additional Substance Use Hotline, but do not staff to a 10-second answer time, will the Commonwealth entertain alternative Performance Guarantees?

Offerors may propose additional performance guarantees.

142. Please clarify whether MISA/EAP will be carved in to the medical vendors or if a single MISA/EAP vendor will be selected for the full population. The MISA Questionnaire tab item VI.2 asks for confirmation that vendors will "administer MISA/EAP benefits for all eligible participants regardless of the medical plan." Please provide additional context on the intent of this statement.

This is incorrect as each medical plan administrator will provide MISA/EAP for their participants. Please refer to the RFP for confirmation.

143. How many face-to-face sessions does the current EAP provide?

Refer to current Member Handbooks for covered EAP visits, including face-to-face visits using a computer or mobile device.

144. Please provide EAP utilization information:

Historical face-to-face EAP utilization for each of the past 3 years.

1. Average number of visits per EAP episode.
2. Number of DOT cases for each of the past 3 years.
3. Number of SAP cases for each of the past 3 years.
4. Historical utilization of training seminars for each of the past 3 years. Provide the number of seminars and the hours used. Please break this down by employee orientation hours and supervisor training hours.
5. Historical utilization of CISDs for each of the past 3 years. Provide the number of critical incidents and the hours used.

Historical face-to-face EAP utilization for each of the past 3 years.

EAP Utilization	COVA	TLC	LODA
Counselor referrals FY18	4.52%	2.19%	0.78%
Counselor referrals FY17	4.27%	2.00%	N/A
Counselor referrals FY16	4.52%	2.01%	N/A

Historical utilization of CISDs

	FY18	FY17	FY16
Trainings	169	272	215
Training Hours	183.5	276	243.5
CIRs	74	59	52
CIR Hours	333.25	280.25	207
EAP Orientations	22	30	43

145. How many EAP critical incident and training hours would you like vendors to propose?

We are interested in your proposal.

146. Please clarify if you are looking for a telephonic work life solution with verified referrals or only online work life services?

We are interested in your proposal.

147. What promotional materials does the current EAP vendor provide? Are these materials emailed to members, mailed to members, or provided to the State to distribute?

We are interested in your proposal.

148. Do you provide member and employee email addresses to the current vendors for email communications?

No.

149. Please describe your current Wellness offering in further detail. What wellness programs do you currently offer to your population? What conditions/issues are targeted today? What is the participation rate for each program? Please provide additional insight into what is working well and what you would like to see improved.

Refer to current Member Handbooks for information on wellness programs offered under each plan and for each population. We are interested in your suggestions going forward.

150. Please provide additional information on your incentive strategy (including dollar values of incentives and activities members can complete for a reward).

For the existing premium reward program, go to http://www.dhrm.virginia.gov/docs/default-source/benefitsdocuments/ohb/spotlight-

2018-version-b.pdf?sfvrsn=2 (see page 6). Remaining programs are defined in the Member Handbooks.

151. How many individuals have completed a health assessment? Of members that complete a Health Assessment, what percent participate in lifestyle modification programs?

Participation has varied from 24,000 to 38,000 employees and/or spouses, which may be driven by other requirements are needed to earn a premium reward. We are interested in your ideas going forward.

152. Please provide additional information on your interest in a wellness champion network. Do you have any wellness champions in place currently, or do you need vendors to help start a network? What type of activities do you want wellness champions to perform ? If a network is in place, what support do vendors currently provide?

We are interested in your ideas going forward.

153. How many biometric screenings do you offer each year, at how many locations and how many people participate? Can spouses participate? What is the utilization per modality for off-site alternatives? Who is the current biometric screening vendor?

Refer to the current Member Handbooks and inserts for information on biometrics related to wellness programs. Currently, the state plans generally rely on participants using their annual routine physical to obtain biometric data. We are interested in your ideas going forward.

154. Please further define the onsite coaching you are considering. Do you have any onsite coaches currently? If so, what services do they provide? What has been most successful?

There is currently one on-site coach available to all self-insured plan participants at Capitol Square HealthCare. The coach provides information related to existing programs.

155. Are these the types of FSA's they offer today or may want to offer in the next plan year?
- Full Medical FSA
- Dependent Care FSA
- Limited Purpose FSA

Please use the information you have.

156. How many HSA accounts does the State have between AETNA and Anthem?

These plans do not currently administer HSA accounts.

157. Does the State contribute to the HSA?

These plans do not currently administer HSA accounts.

158. What are the deposit balances by vendor for HSA?

These plans do not currently administer HSA accounts.

159. Who administers the FSA today, and how many are enrolled?

Use the information you have.

160. Will you be accepting integrated pharmacy medical proposals in addition to the stand alone pharmacy medical fees?

Please refer to the RFP.

161. Is there a specific vendor you are working with to warehouse the data and who is that vendor?

This is not relevant to the current RFP.

162. When can we expect the claims data from AON?

Claim experience has been provided.

163. Is there still a window on when you will be able to answer questions? What is the turnaround date for answers to questions submitted?

The deadline for submitting questions is September 1, 2018. Questions will be answered as soon as possible.

164. Regarding total population health, is that program being continued or discontinued?

Refer and respond to requirements of the RFP.

165. Section 2.1, page 6 - Statewide Plans - Is the Department looking for a total replacement for the ASO portion of dental (component 4) or are you willing to offer more than one carrier?

The intention is to select only one contractor for all components except number five.

166. Section 2.3.2.8, page 7 - Not mark any of the health plan's data with any statement indicating that the date is proprietary, confidential, protected and/or the property of the Contractor.

Please clarify what this provision means, in the context the Offeror's network providers or its network management.

This confirms that the health plan data is the property of the Commonwealth of Virginia and not the Contractor.

167. Section 2.3.4, page 7 - The Contractor must develop and maintain an on-line, real-time directory….

Please clarify the Department's definition of "real-time".

Provider directories must be updated online as soon as the Contractor is aware of the change.

168. Section 2.4.2, page 7 - All network-based plans shall annually produce and submit a HEDIS (or Department-approved substitute)…

Please clarify whether the HEDIS measures that generally apply to Medicaid populations are those that will apply to the statewide dental plans. If a Department-approved substitute is in place, would the Department be willing to share the measures/format with dental Offerors?

The HEDIS measure for Medicaid looks at visits for members ages 2-20. I do not think it will be relevant for the State plan. Regarding the substitute, the answer is: Contractors may offer substitute for consideration by the Department.

169. Section 2.4.3, page 8 - All network-based plans shall apply for NCQA certification before responding to this RFP….

Please clarify whether dental Offerors must be NCQA-certified. NCQA typically is a medical plan certification, not a dental plan certification.

Confirmed

170. Section 2.5.6, page 8 - …The Department requires that diagnostic codes and provider names are captured with the claim.

Please clarify whether diagnostic code capture is required of dental plans. There currently is not a standardly used dental diagnostic code set.

The intent is to capture what services have been provided to the member and the associated cost. Use the dental codes to capture this information.

171. Section 2.7.2.5, page 10 – "what to do in an emergency"

Please provide context relative to "what to do in an emergency." Is this specific to a dental emergency or a benefits emergency?

Benefits emergency

172. Section 2.8, page 10 - …Public sector clients over 50,000 are preferred and all should be included as references=.

Please clarify: is the Department asking that all public sector clients over 50,000 be included as references, or that all public sector clients, regardless of size, be included as references?

Refer to complete reference section, including instructions regarding public sector clients over 50,000 employees that "all should be included as references"

173. Section 2.8.2, page 11 - The Contractor shall annually produce and submit an approved Member Satisfaction Survey.

Please clarify: is there a preferred medium for the survey, e.g., online, mail, etc.?

Provide the medium/media that you are proposing.

174. Section 2.8.8, page 11 - The Contractor(s) shall work with the Department and other vendors in the creation and distribution of single, plan-specific ID cards.

a. Please confirm: each component is not expected to issue its own ID card but rather work with the other vendors to issue a single, common ID card. Confirmed

b. Please provide more information on what information needs included on the identification card from a dental carrier perspective. Include administrator's logo, member/customer service contact number, any other information that a member or provider would need to facilitate the claim process and that can be accommodated on the card.

c. Please clarify the number of numbers/characters in the ID numbers. The ID number provided by the Commonwealth contains seven numeric and two alpha characters.

175. Section 3.3, page 31 - Produce savings from coordination of benefits of at least 1% of non-Medicare paid claims…..

Please confirm applicability of the 1% target to dental plans.

This does not apply to the dental component.

176. Section 3.4, page 32 - Two types of files are regularly provided:
- The Daily Change File…
- The Monthly Audit File…

Please provide sample layouts of the eligibility files and unique ID number that will be used for dental?

Use the link provided in Appendix 5, then click on Documentation and then Record File Formats.

177. Section 5.2.1, page 37 - An Original, a Redacted Electronic Copy and twelve (12) hard/paper and twenty-five (25) electronic copies of the original……Offerors are required to submit a CD containing their response in MS Excel and Word format, as directed by the Attachment 2 Schedules, along with each copy of the proposal.

Please clarify: are proposers to submit 25 un-redacted electronic copies, of which 12 are included within the hard copy proposal binders, or are Offerors to submit 37 electronic copies, 25 of which are separate and 12 of which are included within the binders?

We would like (1) Original Hard copy (1) Redacted electronic Copy on CD.
In addition, provide 12 hard/paper copies and 25 electronic copies on CDs.

178. Section 6.2, page 40 - REDLINE RFP NOTING DEMURRALS (TAB 1) - Include a copy of the RFP. Using the Track Changes and Highlight Changes MS Word tools, annotate in redline any and all demurrals or deviations to the requirements of the RFP.

Please provide a copy of the RFP in MS Word format in order to use the Track Changes and Highlight Changes tools to highlight any demurrals or deviations.

A Word version is available at the DHRM web site - https://www.dhrm.virginia.gov/procurement/requestforproposals

179. Section 8.4.6, page 59 - For state employee and TLC groups, the Medical/Surgical Contractor agrees to bill certain Extended Coverage (COBRA) enrollees and certain retiree group participants designated by the Department for premiums.

Does this pertain to dental carriers? Will the Department require dental carriers to administer COBRA?

As noted, the medical/surgical contractor handles applicable COBRA billing. Dental administrators would only be required to process COBRA claims.

180. Section 8.5.3, page 60 – Surcharges

Please clarify: Offerors quoting on an ASO basis should increase their proposed ASO fees by 2%. If not, please clarify how the surcharge process will work for those plans.

As noted, "All rate projections should include a surcharge of 2% to recognize these costs."

181. Section 8.15, page 62 - INTERNET SITE - Contractor agrees to maintain dedicated Internet sites devoted to enrollees covered under the employee health benefits program, TLC, and LODA. As a minimum, the sites shall contain the following…

Is the Department satisfied with a landing page with links that accommodates these requests, or is a fully functioning internet site required?

There must be a dedicated Commonwealth of Virginia site with access to the listed information.

182. Appendix 3, page 80 - LODA Health Benefits

Do they pertain to dental offerors?

The LODA Health Benefits Plans SPDs include dental coverage information.

183. Attachment Three, page 93 - Report Formats

Please provide samples of the reports required.

As stated in the Appendix the Department does not require special designed reports and will review standard report formats to determine if they meet Department needs. Please submit your standard reports for review.

184. **Dental Questionnaire, Section** II – 60, page 13 - EDCC program

Please confirm that dental plans are expected to participate in the EDCC program.

Please disregard

185. **Dental Questionnaire, Section** IV - 35.a, page 17 - Vendor agrees to cover the cost of periodic plan wide mailings (e.g. ID cards, plan information).

Please provide quantity estimate of employee population to estimate plan-wide mailings.

The employee enrollment has been provided on which to estimate plan wide mailings. Provide your proposal for cost and services/frequency covered.

186. **Dental Questionnaire, Section** IV-7-9, page 19 - Relating to ID cards

In the main portion of the RFP, it was indicated that there would be a single, common ID card across all components. Please clarify whether the dental Offerors are required to offer dental-only ID cards in addition.

See Section 2.8.8 of the RFP.

187. **Dental Questionnaire,** Financial Questionnaire, page 1 - ASO Fee

What is the current fee?

Provide your proposed fee for this RFP.

188. **Dental Benefits Summaries -** Delta benefits summaries

How does Delta reimburse out-of-network claims? Is it the same for both plans?

Current benefit provisions are in the existing Member Handbooks.

189. **Dental Benefits Summaries -** COVA Care 2016 Member Handbook – page 12

Optional Out-of-Network Benefit (applies to LODA – page 31)
Plan payment is reduced by 25%. Provider may Balance Bill for amount above Allowable Charge

Please confirm that this reduction is truly being administered for the plan.

The 25% out-of-network reduction does not apply to routine dental coverage.

190. **Dental Benefits Summaries -** COVA Care 2016 Member Handbook – page 18 - Out-of-Network - When Providers, hospitals and other health care Providers/services have not contracted with the Plan Administrator to deliver health care services to its members they are considered Out-of-Network. For Medical and Behavioral Health services, except in an Emergency, members do not have Out-of-Network benefits unless they have purchased the Out-of-Network option.

Please confirm this applies to dental. If it does, a dental emergency is a widely used term to describe a dental issue involving the teeth or tooth structures that is of high importance to be fixed/treated. This usually involves some sort of pain or swelling. Palliative treatment (D9110) is a general ADA code used for emergency treatment to relieve pain.

However, there are a multitude of services that could fall under the umbrella of a dental emergency. Please confirm how an emergency would be identified on a claim if other than the D9110 procedure code is reported.

Participants do not have to purchase out-of-network coverage to be covered for the allowable charge for covered services from a non-participating provider.

191. **Dental Benefits Summaries -** COVA Care 2016 Member Handbook – page 18 – Out-of-Pocket Expense Limit - This is the maximum amount of money that you pay out of your pocket for certain covered Medical, Behavioral Health and Outpatient Prescription Drug expenses (combined) during the Plan Year. The following count toward the Out-of-Pocket Expense Limit: Deductible, Copayment, and Coinsurance for covered services from Providers and Facilities in your Anthem and BlueCard PPO Medical and Behavioral Health networks and Outpatient Prescription Drug services. Once the limit is reached, almost all other covered expenses are paid in full (100% of the Allowable Charge) for the rest of the Plan Year. The Out-of-Pocket Expense Limit is for a twelve month period and begins again each July 1.

Does the out-of-pocket expense limit apply to any of the COVA dental plans?

Out-of-pocket routine dental costs do not accrue toward the out-of-pocket expense limit.

192. **Dental Benefits Summaries -** COVA Care 2016 Member Handbook – page 24 – Alternative Benefits (applies to Local Choice - page 11; LODA – page 22)
Your Health Plan may elect to offer benefits for an approved, alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long term Inpatient care. Your Health Plan will provide such alternative benefits at its sole option and only when and for so long as Your Health Plan decides that the alternative services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total which would otherwise be paid under this contract without alternative benefits. If Your Health Plan elects to provide alternative benefits for a member in one instance, it will not be required to provide the same or similar benefits for any member in any other instance. Also, this will not be construed as a waiver of the State's right to administer this contract in the future in strict accordance with its express terms.

Please confirm this applies to dental. If it does, could the Department provide what services may have an alternate benefit applied? An example of one of our standard alternate benefit situation is below:
• Amalgam or composite fillings v. crowns and onlays

This does not apply to routine dental services.

193. **Dental Benefits Summaries -** COVA Care 2016 Member Handbook – page 79 –

(applies to local choice - page 59; LODA – page 78) A Health Services Review is recommended prior to an oral surgery procedure.

Does this mean that a predetermination needs to be submitted for all covered oral surgery services so the Advisors can review prior to the service being performed?

A Health Services Review is highly recommended to ensure that that it will be a covered service. However, it is not required.

194. **Dental Benefits Summaries -** COVA Care 2016 Member Handbook – page 80 – Special Limits (applies to local choice – page 60; LODA – page 79)
1) Non-routine Dental services covered under the Medical benefit are subject to the Medical Plan Year Deductible and Out-of-Pocket Expense Limit.

What are the dental procedures covered under medical so dental does not duplicate coverage?

Use the information provided in the Member Handbook.

195. **Dental Benefits Summaries -** COVA Care 2016 Member Handbook – page 82 – applies to local choice- page 57; LODA – page 75) - Delta Dental must approve permanent crowns for Covered Persons under age 16

Does this mean that a predetermination needs to be submitted for members under 16 for all crowns so the Advisors can review prior to the service being performed?

Refer to the conditions for reimbursement in the Member Handbooks.

196. **Dental Benefits Summaries –** The Local Choice – page 20 –
Pre-existing Conditions - A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to enrollment in a health plan. Pre-existing conditions are covered under the Plan. You do not have to satisfy a waiting period before services for pre-existing conditions are covered.

Please confirm this applies to dental. Our standard benefit is not to make payment for crowns, inlays, onlays and post and cores, dentures or fixed partial dentures started prior to the effective date of the member's contract with us. Please confirm that even if these services are started prior to the member's coverage with us, they would be eligible for payment under our plan.

Refer to dental services exclusions.

197. **Miscellaneous -** Claims repricing

Please provide a detailed claims file of dental claims over the past year in order to perform a claims repricing.

Not necessary. Unit cost will be determined by completing the exhibits obtained from the Aon NAPD website.

RFP # OHB19-01
Administrative Services and Fully Insured Health Benefits Plans

Mandatory Pre-Proposal Conference
Monday, August 20, 2018 at 10:30 a.m.

Note: This information will be publicly posted as a part of Addendum #1

Sign In Sheet

	PRINT NAME	COMPANY REPRESENTING	SIGNATURE	CONTACT INFORMATION	PARTNERING WITH
1.	Donna Greif	1. Aon	1.	1. donna.greif@aon.com	1.
2.	Rachael Clark	2. Aetna	2. R. Clark	2. ClarkRae@Aetna.com	2.
* 3.	Bethann Johnson	3. PAYFLEX	3.	3. bjohnson67@payflex.com	3. * Point of Contact Kelly Burkhard kburkhard@payflex.com
4.	Bill Lichota	4. AETNA	4.	4. lichotaw@aetna.com	4.
* 5.	MARCUS DUCKWORTH	5. AETNA	5.	5. DUCKWORTHM@AETNA.COM DUCKWORTHM@AETNA.COM	5.
6.	Marc Vallario	6. NAN	6. Marc Vallario	6. Marc.Vallario@NAN.com	6.
7.	Sean Kuhn	7. Aetna Health	7.	7. rkuhn@Aetnahealth.net	7.
8.	Laura Garrett	8. BenefitFocus	8.	8. laura.garrett@benefitfocus.com	8.
9.	Kathy Tennisice	9. OPTIMA HEALTH	9.	9. KMTENNAS@sentara.com	9.
~~10.~~ *	Stacy Fuqua	10. Optima Health	10. SFuqua	10. SRFUQUA@Sentara.com	~~10.~~

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	PRINT NAME	COMPANY REPRESENTING	SIGNATURE	CONTACT INFORMATION	primary √ PARTNERING WITH
11.	Mark Copenhaver	11. ~~Express Scripts~~ Express Scripts	11. Mark N Copenhaver	11. MNCopenhaver@express-scripts.com 610-864-1059	* 11. Kevin McHugh KHMcHugh@Express-Scripts.com
* 12.	Matt Macdonald	12. Delta Dental	12.	12. matt.macdonald@deltadentalva.com	12.
13.	Ryan O'Donnell	13. Delta Dental	13.	13. ryan.odonnell@deltadentalva.com	13.
14.	DAVE WERNER	14. Delta Dental	14. DWWer	14. dwwerner@deltadentalva.com	14.
* 15.	Maureen Breheny	15. Kaiser Permanente	15. MBreheny	15. maureen.m.breheny@kp.org 703-795-0588	15.
16.	Ashley Wallace	16. Kaiser Permanente	16.	16. ashleyd.wallace@kp.org	16.
17.	Patty Marshall	17. Anthem	17. Patty Marshall	17. patty.marshall@anthem.com	17.
18.	Laura Edwards	18. Anthem	18.	18. Laura.edwards@anthem.com	18.
* 19.	ERIK GEREW	19. Alight Solutions LLC	19.	19. erik.gerew@alight.com	19.
20.	Bill Deal	20. UnitedHealthcare	20.	20. William.deal@UHC.com	20.

RFP # OHB19-01

Administrative Services and Fully Insured Health Benefits Plans

Mandatory Pre-Proposal Conference

Monday, August 20, 2018 at 10:30 a.m.

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Sign In Sheet

PRINT NAME	COMPANY REPRESENTING	SIGNATURE	CONTACT INFORMATION	PARTNERING WITH
21. James Moores	21. Anthem	21. James S Moores	21. james.moores@anthem.com	21.
22. Mike Newberry	22. Anthem	22.	22. Mike.Newberry2@anthem.com	22.
23. John Schantz	23. Anthem	23.	23. John.Tschantz@Anthem.com	23.
24. Elizabeth Meyers	24. United Concordia	24. Elizabeth Meyers	(919) 270-4404 set card 24. elizabeth.meyers@ucci.com	? to receive updates * 24. todd.kreider@ucci.com
25. Duncan Sheils	25. Anthem	25.	25. duncan.sheils2@anthem.com	25.
* JOSH KUGELMAN	26. ANTHEM	26.	26. JOSH.KUGELMAN@ANTHEM.COM	26.
27.	27.	27.	27.	27.
28.	28.	28.	28.	28.
29.	29.	29.	29.	29.
30.	30.	30.	30.	30.

Department of Human Resource Management
Administrative Services and Fully Insured Health Benefits Plans
RFP # OHB19-01

Attendees for Mandatory Pre-proposal Conference
Held on August 20, 2018 at 10:30 a.m.

ActiveHealth MANAGEMENT.

R. Sean Kuhn
Vice President, Sales
rkuhn@activehealth.net
www.activehealth.com

1333 Broadway
4th Floor
New York, NY 10018
p: 201.341.2660
f: 212.448.0096

James E. Moores
Account Manager III,
Consultant

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
Richmond, VA 23230
VA2003-N110
Tel 804 354-7343
Fax 804 354-4884
James.moores@anthem.com

Anthem. BlueCross BlueShield

Marcus Duckworth
Vice President, Client Management
Public Sector

2010 Corporate Ridge Road, Suite 300
McLean, VA 22102

DuckworthM@aetna.com
770-685-9877 T

aetna

Anthem.

Duncan Sheils
Regional Vice President
Anthem National Accounts
Specialty Distribution

Anthem, Inc.
2015 Staples Mill Road
Richmond, VA 23230
Tel (804) 354-4032
Cell (804) 338-6579
duncan.shelis2@anthem.com
antheminc.com

Erik Gerew, MBA
Sales Executive, Health Point Solutions
Health & Wealth Solutions

alight

Alight Solutions
4 Overlook Point
Lincolnshire, IL 60069
M +1.847.363.2737
erik.gerew@alight.com

BENEFITFOCUS®
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Laura Garrett
Account Executive, Enterprise Accounts

M 804.334.0666

100 Benefitfocus Way, Charleston, SC 29492
laura.garrett@benefitfocus.com

Joshua R Kugelman
Director
State & Local Government

www.anthem.com

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
Richmond, VA 23230
VA2003-N110
Tel 804 354-3264
Fax 804 354-4884
Josh.kugelman@anthem.com

Anthem. BlueCross BlueShield

DELTA DENTAL

Matt Macdonald
Account Executive

Delta Dental of Virginia
4860 Cox Road, Suite 130
Glen Allen, VA 23060

Telephone: 804-527-0079
Fax: 804-527-1870
Email: matt.macdonald@deltadentalva.com

Department of Human Resource Management
Administrative Services and Fully Insured Health Benefits Plans
RFP # OHB19-01

Attendees for Mandatory Pre-proposal Conference
Held on August 20, 2018 at 10:30 a.m.

DELTA DENTAL

Ryan J. O'Donnell
Account Manager

Delta Dental of Virginia
4860 Cox Road, Suite 130
Glen Allen, VA 23060

Telephone: 804.297.3268
Mobile: 540.632.9871
Email: ryan.odonnell@deltadentalva.com
fax: 804.527.1870

DELTA DENTAL

David N. Werner, CEBS
Vice President, Sales

Delta Dental of Virginia
4860 Cox Road, Suite 130
Glen Allen, VA 23060

Telephone: 804-527-1393
Toll Free: 800-533-4137
Fax: 804-527-1870
Email: dwerner@deltadentalva.com

Express Scripts
Federal Pharmacy Services

EXPRESS SCRIPTS Federal Pharmacy Services
TRICARE

Mark Copenhaver
Account Executive, National Capital Area
MTF Pharmacies

MNCopenhaver@express-scripts.com
(202) 897-7129

OptimaHealth

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Stacy Fuqua
Director, Strategic Sales & Client Development, Public Sector

work: 757-687-6060
cell: 757-536-5557
srfuqua@sentara.com

optimahealth.com

4417 Corporation Lane • Virginia Beach, VA 23462

OptimaHealth

A Service of Sentara

Katherine M Terribile
Senior Regional Client Executive
Sales and Marketing

434-923-8010
434-923-4092
kmterrib@sentara.com

optimahealth.com

P. O. Box 589 • Ivy, VA 22945

PAYFLEX®

Beth Ann Johnson
Senior Sales Executive

O: 860.273.9575
C: 860.817.3737
johnsonb7@aetna.com

151 Farmington Avenue, RT54
Hartford, CT 06156

Connect with me on LinkedIn!

Contact: Kellie Burkhard
Kburkhard@payflex.com

PAYFLEX®

www.payflex.com

UNITED CONCORDIA DENTAL

to receive updates

Elizabeth Meyers
Regional Sales Manager

4860 Cox Road
Suite 200
Glen Allen, VA 23060

todd.kreider@ucci.com

office 804-217-8342
cell 919-270-6404
elizabeth.meyers@ucci.com

Department of Human Resource Management
Administrative Services and Fully Insured Health Benefits Plans
RFP # OHB19-01

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Held on August 20, 2018 at 10:30 a.m.

William Deal
Sales VP, Public & Labor
Northeast Region
Public Sector and Labor Markets

UnitedHealthcare

100 Penn Square East
Philadelphia, PA 19107
william.deal@uhc.com

m 610.217.7348
f 855.690.5966

Appendix 9

Proposal Checklist

Complete the form below in full, sign in blue ink the completion certification at the bottom of the form, and enclose it following the Cover Sheet as directed in RFP Section 6.

Offeror:

1.a. Indicate the plan design you have proposed by checking the appropriate blocks:

RFP Components					
Component 1: Statewide PPO and HDHP Medical/Surgical; Behavioral Health w/ EAP; Vision; and Hearing Services for the State Employee, TLC, and LODA Plans	**Component 2: Statewide CDHP Medical/Surgical; Behavioral Health w/ EAP; Vision; and Hearing Services for the State Employee Program**	**Component 3: Statewide PPO, HDHP, and CDHP Prescription Drug Services for the State Employee, TLC, and LODA Plans**	**Component 4: Statewide PPO, HDHP, and CDHP Dental Services for the State Employee, TLC, and LODA Plans.**	**Component 5: Fully-insured Regional Plans for State Employee and TLC Programs**	**Component 6: Section 125 Flexible Spending Account Administration for State Employees**

1.b. If you have proposed a Fully-Insured Regional HMO or PPO with less than statewide coverage, check the block below to affirm that you have attached a copy of your HMO license, and/or, for either network configuration, a document showing the cities/counties comprising your service area.

(1) HMO license showing service area enclosed with Tab 1.

(2) Quoting under exception provision as briefly described below.

2. If you have proposed any network-based plans, affirm, by checking the appropriate blocks below, that you meet the Mandatory Minimum Qualifications stated in this RFP. Your affirmation will also declare your intent to submit appropriate documentation as may be required to demonstrate these qualifications are met throughout the contract period.

Mandatory Qualifications for Contractors	**Meet Standard (3)**
a. Meet GeoAccess standard as specified in Section 2, or	
b. Will apply for Certificate as specified in Section 2.4.1	
c. Will submit HEDIS report annually	
d. Will submit specified member satisfaction results annually	
a. Benefits Exceptions Description	
f. Comply with Section 2.4.4. area coverage requirement (or claim test file requirement)	
g. Comply with toll-free service requirement	

3. Affirm below that you are in agreement with the Standards of Performance specified in RFP Section 3, including the Schedule of Liquidated damages, and will provide the requested documentation and claims tapes substantiating your performance and will meet the claims file test requirements if you are a finalist.

Statement	**Agreement (3)**

4. Affirm, by checking the appropriate block below, that you have completed and submitted all of the following required proposal components as required in RFP Section 6.

Proposal Item	**Completed and Submitted (3)**
a. Cover Sheet, original signed in blue ink	
b. This Proposal Checklist and Questionnaire, original signed in blue ink	
c. Redacted version of submission excluding Confidential/Proprietary information	
d. Redlined version of the RFP showing all demurrals	
e. Benefits exceptions description	
f. Benefits brochure	
g. All questionnaires and exhibits as required in formats specified in Attachment 2	
i. Small Business Participation detail (Exhibit Two)	

5. **Virginia State Corporation Commission (SCC) registration information**. **The Offeror:**

- is a corporation or other business entity with the following SCC identification number: _____ **-OR-**
- is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**
- is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the offeror in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from offeror's out-of-state location) **-OR-**
- is an out-of-state business entity that is including with this proposal an opinion of legal counsel which accurately and completely discloses the undersigned offeror's current contacts with Virginia and describes why those contacts do not constitute the transaction of business in Virginia within the meaning of § 13.1-757 or other similar provisions in Titles 13.1 or 50 of the Code of Virginia.

****NOTE**** Check the following box if you have not completed any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for proposals (the Commonwealth reserves the right to determine in its sole discretion whether to allow such waiver):

Offeror's Signature	Date